THE CONTROL OF VENEREAL DISEASES UNDER THE NATIONAL HEALTH SERVICE*

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The present time seems appropriate for a discussion on the control of venereal diseases under the National Health Service because important discussions on working arrangements, terms, and other matters are now taking place between representatives of the medical profession and the Ministry of Health, and large numbers of medical practitioners who have served as specialists in the Armed Forces are wondering whether any and what use is likely to be made of their skill and experience when the new Service is set up.

It seems natural to enquire whether the National Health Service is likely to provide conditions for the control of venereal disease that are an improvement on the present, and if so in what respects; also whether it is likely to provide employment for more specialists in venereal disease than under present conditions. Without prejudice to any views I may hold on the National Health Service generally, and speaking only for the Service as it concerns England and Wales, I think that a wonderful opportunity is offered for improving the present venereal disease service. In support of this, I would first offer some criticisms of the venereal disease service under present conditions.

The Present Position

At present the authorities responsible to the Minister of Health for arrangements under the Public Health (Venereal Diseases) Regulations, 1916, are the County Councils and the County Borough Councils, who are required to provide facilities for the examination and any necessary treatment of persons suspected of suffering from syphilis, gonorrhœa, and/or soft chancre and for the laboratory examination of specimens of material from such persons. They are also required to work Regulation 33B as long as it is in force, and they are exhorted by the Minister of Health to educate the public in the facts about venereal diseases; to provide social service designed to encourage attendances for treatment, to follow up those who discontinue attendance prematurely, and to trace and persuade contacts to undergo examination etc.

In all this work they are allowed, under the Local Government Act of 1929, a large amount of discretion. Provided that medical officers appointed to charge of treatment centres comply with certain requirements in respect of knowledge and experience—requirements which were designedly made very mild in 1930 when specialists were relatively scarce and posts in country centres were not easy to fill—they need not submit any appointment for approval by the Minister of Health; this is unlike the position before 1930, when the Minister could always ask an appointing authority to choose again. The appointment now may be made by the governing body of a hospital or directly by a local authority, according to the locus of the treatment centre; but there is no provision to ensure that the electing body is qualified by knowledge of the requirements to choose the most suitable candidate. In such circumstances it is perhaps not surprising that on occasion the most suitable candidate has not been elected.

The approval of the Minister of Health is not necessary for any change in the arrangements that does not involve a curtailment of facilities. On the other hand, except in the case of expansions necessitated by war conditions and recognized as such by the Minister, the local authority cannot look to the Minister for reimbursement of any part of the cost of any improvement which they may make in

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their venereal disease service until the end of the five-year period when the amount of their block grant for all grant-aided services is re-fixed; as during the years 1916–30 local authorities were educated to expect reimbursement of 75 per cent. of their expenditure on venereal disease, the present conditions of repayment are discouraging. If a centre has become too small for its turnover; if there is shortage of staff; if the number of sessions per week has become too few for the work to be properly done; if the hours spent by the medical staff over the work have become more than were calculated necessary when the salaries were originally fixed, if in fact the staff is being sweated; then the remedy depends on a body which probably starts to consider the matter with a strong bias against incurring more expenditure and, being ignorant of the requirements, does not feel the urgency of the matter. In such circumstances it may not be surprising that, on occasion, delaying tactics are employed. The question is referred to a committee, which instructs the medical officer of health to make a report. In due course the report is presented, but then perhaps it is too close to the municipal elections for the matter to be considered by the Council and it is postponed until after the elections. Meantime the medical officer of the treatment centre struggles on, unhappily seeing his centre become what Surgeon-General Parran has so aptly described as a treatment mill.

Treatment Centres

Treatment centres under present conditions are more or less self-contained units, and in many cases the medical staff consists of only one medical officer. In the Provinces particularly, the frequent result of this is that when such a medical officer cannot attend his place has to be filled temporarily by someone, such as a resident medical officer, who may be very inexperienced in the management of venereal disease. Moreover, the treatment centre is often in a place where there is not enough venereal disease to employ a medical officer whole-time, and the medical officer of the treatment centre is not only primarily interested in some other branch of medicine but in respect of venereal disease he "ploughs the lonely furrow," having nobody near him with whom he can talk shop. A census which I made in 1939 of the medical staffs of the 156 centres in the Provinces in England, showed that they had 259 medical officers (216 male and 43 female); and, of the 259, only 36 were primarily specialists in venereal diseases. Of the remainder, 16 were described as dermatologists; 14 as pathologists; and 66 as medical officers of health or assistant medical officers of health; I need not detail the prime interests of the remainder. Even in London, where there were 23 centres with 98 medical officers, only 11 of the centres had medical officers who were primarily specialists in venereal disease, and there were 10 dermatologists; the remainder were described as physicians, surgeons, pathologists, anæsthetists, general practitioners, electro-therapists, and psychologists.

Available Personnel

At the present time, as we know, there are a large number of medical practitioners who have gained valuable experience in the management of venereal disease whilst serving with the Armed Forces, but their appointment to charge of or service in venereal disease treatment centres depends on: (*a*) the occurrence of vacancies created by casualties in the existing staffs, and (*b*) their election by committees which very often do not know the requirements. Further, the conditions of many of the lonely appointments are such as whole-time specialists in venereal disease could not accept, because, with due regard to economy of public expenditure, the salaries which can be offered for charge of such small centres cannot be sufficient in themselves for the maintenance of a medical practitioner.

It does not seem necessary here to criticize the section of the venereal disease service which depends on the work of practitioners enrolled under the Ministry of Health's Circular No. 2226 to treat patients in their own surgeries, because it can be dealt with adequately when we speak of the venereal disease service as one hopes it will be under the National Health Service.

The Laboratory Service

There remains for criticism the laboratory section of the venereal disease service. In too many laboratories which have been approved under the Venereal Disease Regulations the work of serum-testing is relegated to technicians. The Local Government (Qualifica-

tions of Medical Officers etc.) Regulations, 1930, lay down certain fairly stringent conditions for qualification as an approved Venereal Disease Pathologist for the purposes of the Venereal Disease Regulations, and it must be obvious that those conditions were drafted with the intention that only persons possessing them should be entrusted with serum testing and the other work of a venereal disease pathologist. Relegation of this work to a technician who is not qualified under the Regulations is a breach of the Agreement under which the institution which houses the laboratory in question carries out the work under the Venereal Disease Regulations in return for fees calculated on the assumption that a fully-trained and experienced pathologist would do it. The common reply to the criticism that the approved pathologist at a given approved laboratory does not actually perform the tests is that although he does not do so, he supervises the work of the technician and holds himself responsible for its accuracy. However, anyone with experience of serum testing knows that one could supervise serum testing adequately only by watching the measurement of every reagent and its addition to the tube that has been laid out for its reception; very little imagination is needed to realize that under such conditions the supervisor might just as well do the work himself.

The Future

How can the venereal disease service be improved through the operation of the National Health Service? First, I suggest that in each region there should be a regional consultant who is director of a treatment centre in the region. The consultant should be appointed by the Minister of Health, and he should be a member of the Regional Hospital Board, or at least be co-opted by the Board whenever the subject of venereal diseases is discussed. His duties should include: (*a*) assistance to directors of treatment centres in his region in securing conditions conducive to the efficiency of their centres; (*b*) supervision of the practitioners employed under the provisions of the Ministry's Circular 2226, or its equivalent, to see patients in their own surgeries, if this service is considered worth continuance; (*c*) securing and maintenance of a proper liaison between the treatment centres and the social services under the medical officers of health in respect of such work as the tracing of contacts by visiting whenever contacts cannot be secured by other means; (*d*) the organization of regional conferences of venereal disease officers for discussion of matters of interest to the regional venereal disease service.

The Treatment Service

The treatment service should comprise treatment centres in the towns, and for rural areas a general practitioner service on similar lines to that now operating under the Ministry of Health's Circular No. 2226.

The treatment centres should be of two main kinds, headquarters and subsidiary, and every subsidiary centre should be staffed by the headquarters centre to which it is subsidiary. Such an arrangement would have the advantages that: (*a*) every centre would eventually be staffed by specialists in venereal disease, or by practitioners who for the time being were working only in this branch of medicine; (*b*) there would be no ploughing the lonely furrow by directors of small venereal disease treatment centres; and (*c*) there would be continuity of skilled service practically undisturbed by casualties to individual members of staffs. The staff and equipment of subsidiary centres might well be transported there in motor vehicles; thus every such centre could have practically as good equipment as that in a headquarters centre, even to an incubator, which could be paraffin-heated and fitted into the motor vehicle.

Directors of headquarters centres should be elected by Regional Hospital Boards, helped by the advice of their regional consultants. Assistants in a venereal disease treatment centre should be appointed by the Management Committee or the Board of Governors of the hospital responsible for the general administration of the headquarters centre.

The Social Service

For the social service each centre, whether headquarters or subsidiary, should have one or more almoners, for the encouragement of attendances, for following up defaulters, and for persuasion of patients to persuade their contacts to attend. But for such contact-tracing as requires domiciliary visits the social services of public health departments should be employed.

Laboratory Tests

Laboratory tests will presumably be carried out for the most part in the laboratories of the hospitals at which headquarters centres are established. My view is that when the venereal disease service is established under the National Health Service steps should be taken to ensure that laboratory tests of material from persons suspected of suffering from any of the venereal diseases are carried out by officers who possess at least the qualifications laid down for venereal disease pathologists in the Local Government (Qualifications of Medical Officers etc.) Regulations, 1930. Further, I think that the Venereal Disease Reference Laboratory should be continued.

It is far too little realized at present that the testing of a specimen for evidence of venereal disease is a serious matter which may affect the whole future of the person from whom the specimen was derived. Every specialist in venereal disease must often have wished that he could bring home to the responsible pathologist the distressing consequences of a false positive serum reaction. The responsibility for the consequences of a false positive cannot lightly be shifted to the clinician by saying that the pathologist does not make the diagnosis; in certain circumstances the evidence of the pathologist may be crucial. Some months ago I was asked to see a married man, a member of one of the learned professions who for three months had been attending a dermatologist for what I proved to be a syphilitic rash; the proof was by demonstration of *S. pallida* in the juice from a typical mucous patch and by the serum reactions. Everything was open and aboveboard in respect of domestic relations, perhaps chiefly because it was clear that the infection must have been acquired innocently, and at once steps were taken to have the wife's blood tested. The test was done by a laboratory to which the family practitioner sent the specimen, and the report was that the Wassermann reaction was strongly positive. Fortunately, I had advised that, although the chances of the wife being infected seemed very strong, they should on no account accept the first test as conclusive, whether the report was positive or negative. In consequence of this I had the opportunity to take further specimens of blood, of which three in succession were found completely negative, one of the specimens being tested in two laboratories. In this case the husband was a highly-strung intellectual who went through hell in the interval between my diagnosis of his own condition and the first negative. I need say no more to emphasize that we ought all to press hard for the principle that the venereal disease pathology must be in the hands of people who have been thoroughly trained in the work and are moreover fully conscious of the implications of their reports.

In my view the Venereal Disease Reference Laboratory is still a necessity. It originated in 1924 from the difficulty of persuading venereal disease pathologists that their respective test methods might be worth revision. It is useless arguing with a pathologist that one would judge from his protocols that his test could be improved; the only thing to do is to invite him to test 200 or more sera supplied to him from a central source, in parallel with a reliable tester practising a method which has itself been through the fiery ordeal of a comparison of methods applied to a large number of unknown sera. On these lines a fairly large number of comparisons were run between 1924 and 1939 and in each case the results of both pathologists' tests were put together side by side with the clinical diagnoses, which were disclosed to the pathologists only after the results had been reported; the effect frequently was some heartburning and often also a determination to revise a test method. Further the Venereal Disease Reference Laboratory has often acted as a court of appeal in the case of anomalous results, and during the late war it was a godsend to many laboratories in providing reagents for serum tests, including preserved complement serum in a liquid state. The Venereal Disease Reference Laboratory has been transferred to the Medical Research Council, and I should like to emphasize that there is no idea in my mind of making the pathologist in charge of it in any way a supervisor of venereal disease laboratories.

The venereal disease service has few friends outside its own ranks, and we shall get efficient conditions only by fighting hard for them.